

ProChoiceLife: Asking Who Protects Life and How— and Why It Matters in Law and Politics*

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INTRODUCTION

Government can protect new life in many ways. It can restrict a woman's access to abortion, help a woman avoid an unwanted pregnancy, or help a pregnant woman bear a healthy child.

If we expand the frame and analyze restrictions on abortion as one of many ways government can protect new life, we observe facts that escape notice when we debate abortion in isolation. Jurisdictions that support abortion rights may protect new life in ways that jurisdictions that restrict abortion rights will not. One jurisdiction may protect new life by means that respect women's autonomy, while another protects new life by means that restrict women's autonomy.

In this Essay I reason from a "prochoicelife" perspective that asks whether government protects new life by means that respect women's reproductive decisions. I develop a framework that allows us to compare the policies for protecting new life that governments choose and the values they demonstrate. This Essay's critical framework connects policies on sexual education, contraception, abortion, health care, income assistance, and the accommodation of pregnancy and parenting in the workplace. It shows that some jurisdictions protect new life selectively, favoring policies for protecting new life that restrict women's reproductive decisions over policies that respect women's reproductive decisions.

Fresh description generates new prescription. Asking who protects life, and how, matters in enforcing the Constitution and in forging coalitions across divided communities. Scrutinizing the state's interest in protecting life strengthens protections for abortion rights under the Supreme Court's most recent decision in *Whole Woman's Health v. Hellerstedt*.¹ Yet the Essay assumes that debate over abortion rights—and reproductive justice more generally—is not confined to courts. It frames questions about what it means to protect life on broader grounds that all can engage, on the understanding that we debate questions of abortion rights and reproductive justice in popular as well as legal arenas.²

Debates about abortion conventionally focus on the woman-fetus dyad alone. In this narrow framework, protecting unborn life seems to require controlling women. When we focus on abortion alone, opposing women's choices seems like the most powerful expression of a commitment to protect life. But restricting access to abortion is not the only way to reduce the number of abortions, or to protect new life.

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1. 136 S. Ct. 2292 (2016); see *infra* Part III.A.

2. See *infra* Part III.B.

This Essay expands the conventional frame of the abortion debate along temporal and relational lines. Women's decisions about abortion are shaped by circumstances that women face before conception and can foresee after birth. For this reason, a state that sought to reduce abortion and protect new life would not only focus on restricting abortion.

In fact, global studies show that highly restrictive abortion laws make abortion unsafe for women but do little to lower abortion rates.³ Access to contraception may play a more important role.⁴ Studies in the United States show that access to effective contraception dramatically reduces unwanted pregnancies *and* reduces the abortion rate.⁵ And government can protect new life by assisting pregnant women who wish to become mothers. Providing access to affordable health care protects life⁶

3. See GUTTMACHER INST., INDUCED ABORTION WORLDWIDE 1–2 (2017), https://www.guttmacher.org/sites/default/files/factsheet/fb_iaw.pdf [<https://perma.cc/4U8W-QADH>] (“Highly restrictive abortion laws are not associated with lower abortion rates. When countries are grouped according to the grounds under which the procedure is legal, the rate is 37 abortions per 1,000 women of childbearing age where it is prohibited altogether or allowed only to save a woman’s life, compared with 34 per 1,000 where it is available on request, a nonsignificant difference.”).

4. *Id.* at 2 (“High levels of unmet need for contraception help explain the prevalence of abortion in countries with restrictive abortion laws.”).

5. See, e.g., M.A. Biggs, C.H. Rocca, C.D. Brindis, H. Hirsch & D. Grossman, *Did Increasing Use of Highly Effective Contraception Contribute to Declining Abortions in Iowa?*, 91 CONTRACEPTION 167 (2015) (finding a decline in abortion followed increases in use of long-acting reversible contraception (LARC) in Iowa); Jeffrey F. Peipert, Tessa Madden, Jennifer E. Allsworth & Gina M. Secura, *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 OBSTETRICS & GYNECOLOGY 1291 (2012) (finding that the teenage pregnancy rate among a cohort of adolescents given counseling on all reversible contraception with an emphasis on LARC methods was 6.3 per 1000, compared to that national average of 34.1 per 1000); Sue Ricketts, Greta Klingler & Renee Schwalberg, *Game Change in Colorado: Widespread Use of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women*, 46 PERSP. ON SEXUAL & REPROD. HEALTH 125 (2014) (finding that an increase in provision of LARCs to women in Colorado as part of the Colorado Family Planning Initiative led to a 24% decline in the proportion of births that were high-risk between 2009 and 2011 and that abortion rates fell 34% and 18%, respectively, among women aged 15–19 and 20–24). While some antiabortion advocates attribute falling abortion rates to restrictive laws that compel women to stay pregnant, data contradicts this notion. As one scholar has suggested, “[i]f women’s attitudes were really shifting, we should see the birth rate go up Instead, birth rates are falling too.” Amelia Thomson-DeVeaux, *The Abortion Rate is Falling Because Fewer Women Are Getting Pregnant*, FIVETHIRTYEIGHT (June 12, 2015, 10:51 AM), <https://fivethirtyeight.com/features/the-abortion-rate-is-falling-because-fewer-women-are-getting-pregnant> [<https://perma.cc/ZH97-ZK74>]. This drop in birth rates, studies suggest, is better explained by increased contraception’s facilitation of lower rates of unplanned pregnancy. See Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 PERSP. ON SEXUAL & REPROD. HEALTH 3 (2014) (finding no evidence during a 2008 and 2011 study period to suggest that new abortion restrictions affected abortion incidence at the national level and instead attributing recent declines in the birthrate to increased contraception use).

6. See HEALTH RES. & SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., CHILD HEALTH USA 2013, at 32 (2013), <https://mchb.hrsa.gov/chusa13/dl/pdf/chusa13.pdf>

—“[n]ewborns of mothers who do not receive prenatal care are . . . five times more likely to die than children born to mothers who do receive prenatal care”⁷—and reduces incentives to pursue abortion.

Appreciating that states can protect new life by means that respect women’s reproductive decisions and by means that restrict women’s reproductive decisions allows us more precisely to characterize the policy preferences of jurisdictions that restrict abortion.

We generally assume that states restrict abortion out of a benign concern to protect unborn life. It is for this reason that jurisdictions that restrict abortion call themselves “prolife.” But expanding the frame raises questions about this standard premise. A jurisdiction may single out abortion as a means of protecting new life, but do little to help women avoid unwanted pregnancy or to help women bring a wanted pregnancy to term. This Essay compares the ways that states protect new life and shows that *many prolife jurisdictions lead in policies that restrict women’s reproductive choices and lag in policies that support women’s reproductive choices*.⁸ Comparing state policies in this way makes clear that the means a state employs to protect new life reflects views about sex and property, as well as life.⁹

Revising the standard descriptive account of the values funding abortion restrictions has prescriptive implications. States are of course entitled to act on their policy preferences about protecting sex and property, as well as life, but these preferences do not all command equal deference. *States that protect new life selectively, favoring choice-restricting over choice-supporting means of protecting life, deserve less deference ethically, politically, and legally.*

For this reason, expanding the frame to ask prochoicelife questions matters, inside the abortion context and outside of it, in politics and in law.

Expanding the frame matters in debates over abortion: advocates can ask whether states protect life selectively when advocates oppose restrictions on abortion in state legislatures, when they communicate with the public about the stakes of abortion rights litigation, and when they reason with judges about a legislature’s justifications for restricting abortion. By asking whether states protect new life selectively or consistently, advocates can extend the Court’s reasoning in *Whole Woman’s Health*,¹⁰ from health-justified restrictions on abortion to fetal-protective restrictions on the procedure.¹¹

Expanding the frame matters outside the abortion context: Focusing attention on

[<https://perma.cc/3GJJ-9ZJT>] (“Early and adequate prenatal care helps to promote healthy pregnancies through screening and management of a woman’s risk factors and health conditions, as well as education and counseling on healthy behaviors during and after pregnancy.”).

7. NAT’L WOMEN’S LAW CTR., MEDICAID COVERAGE FOR PREGNANT WOMEN REMAINS CRITICAL FOR WOMEN’S HEALTH 1 (2015), https://nwlc.org/wp-content/uploads/2015/08/medicaid_coverage_for_pregnant_woman3.pdf [<https://perma.cc/C3PX-PLL2>]; see also OFFICE ON WOMEN’S HEALTH, U.S. DEP’T OF HEALTH & HUMAN SERVS., *Prenatal Care Fact Sheet*, <https://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html> [<https://perma.cc/2SJQ-HQE3>].

8. See *infra* Part I.

9. See *infra* Part II.

10. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

11. See *infra* Part III.A.

the many contexts in which a community can protect new life may help forge prochoicelife coalitions within and across party lines, whether in support of health care and job security for pregnant women or to protect access to contraception.

This Essay proceeds in three parts. Part I expands the temporal and relational frame of the abortion debate and examines the choices about protecting life that leading abortion-restrictive jurisdictions make. It demonstrates that leading abortion-restrictive jurisdictions act inconsistently about protecting life in a variety of settings. Part II considers the values that might explain these policy decisions, exploring the judgments about sex, property, and life that could account for the policy preferences of prolife legislators. The exercise demonstrates the importance of factual inquiry in determining the values that abortion restrictions serve, even when legislators characterize such restrictions as protecting life.

Part III considers how expanding the frame to ask prochoicelife questions matters in law and politics. I show first that these questions can guide courts in applying the Supreme Court's decision in *Whole Woman's Health* to abortion restrictions asserted to protect life. I then consider how these questions could inform political debate outside the abortion context, taking health care policy as my example. My goal in probing the assumed conflict between respecting women and protecting life is to build coalitions and communities committed to supporting both.

I. EXPANDING THE FRAME: HOW STATES PROTECT LIFE

In the law and politics of abortion, it is conventional to assume that states restrict women's access to abortion out of an interest in protecting new life. If this is in fact the concern that animates abortion restrictions, these values ought to guide policies outside as well as inside the abortion context. In what follows, I explore this assumption by locating abortion law in a larger policy field.

As theorists of reproductive justice emphasize, many kinds of laws shape the conditions in which women conceive and bear children.¹² Laws on sexual education,

12. A reproductive justice analysis focuses on the conditions in which women make decisions about having children. The inquiry is structural and intersectional, attentive to the differences of power, status, and circumstance among women that shape women's decisions about childbearing. See Loretta Ross, SISTERSONG WOMEN OF COLOR REPROD. HEALTH COLLECTIVE, *What is Reproductive Justice?*, in REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 4, <https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fid=4051> [<https://perma.cc/VSL7-83ZH>] ("The Reproductive Justice framework analyzes how the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community—and these conditions are not just a matter of individual choice and access. Reproductive Justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny."); see also ASIAN CMTYS. FOR REPROD. JUSTICE, A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE JUSTICE 1 (2005), <http://strongfamiliesmovement.org/assets/docs/ACRJ-A-New-Vision.pdf> [<https://perma.cc/6DYK-YKMH>] ("We believe reproductive justice . . . will be achieved *when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives.*") (emphasis in original); Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. L. & SOC. SCI. 327, 343

contraception, abortion, health care, welfare, and employment all can play a role in protecting new life as they change the contexts in which women make decisions about conception, abortion, and childbearing, and as they alter the resources available to pregnant women and new mothers. A government that wished to reduce the number of abortions would not rely on abortion law alone, even in jurisdictions where it is permissible to criminalize the practice.¹³ Access to contraception reduces abortion rates.¹⁴ Nor would a government that sought to protect unborn life focus only on abortion. Providing pregnant women access to health care predictably decreases infant mortality.¹⁵

Expanding the frame and analyzing abortion restrictions in a larger policy context allows us to ask whether states that favor abortion restrictions also help women avoid unwanted pregnancy and support pregnant women who wish to bear healthy babies. Is state interest in protecting new life consistent across contexts, or selective? Do states protect life in ways that enhance or restrict women's autonomy? Do states that restrict abortion also support new mothers and new life?

A. State Interest in Protecting New Life: A Note on Method

Some have evaluated states' protection for life by analyzing measures such as maternal or infant mortality rates.¹⁶ These outcome measures offer critical indicators of state protection for life, yet I do not make them central to this analysis. Evaluating states' protection for life through outcome measures of this kind leads to a debate over contributing factors, only some of which may be subject to state control. For these and other reasons I have focused my analysis on the *policy choices* individual states make.

(2013) (“[R]eproductive justice is equally about the right to not have children, the right to have children, the right to parent with dignity, and the means to achieve these rights. . . . [T]he nominal universalism of rights, especially the right to privacy, masks structural disparities based on race, sexuality, gender, class, and disability, among other axes.”).

13. See *supra* note 3 and accompanying text (discussing persistence of abortion in jurisdictions that criminalize the practice).

14. See *supra* notes 4–5 and accompanying text.

15. See *supra* text accompanying note 7.

16. For richly sourced examples, see BRIDGIT BURNS, AMANDA DENNIS & ELLA DOUGLAS-DURHAM, IBIS REPROD. HEALTH, EVALUATING PRIORITIES: MEASURING WOMEN'S AND CHILDREN'S HEALTH AND WELL-BEING AGAINST ABORTION RESTRICTIONS IN THE STATES: STATE BRIEF: TEXAS 6–7 (2014), https://www.ibisreproductivehealth.org/sites/default/files/files/publications/Ibis%20Reproductive%20Health_Priorities_TX_FINAL_120514.pdf [<https://perma.cc/VNS8-BNFT>]; CTR. FOR REPROD. RIGHTS, A PIVOTAL MOMENT: 2014 ANNUAL REPORT (2015), <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CRR-2014-Annual-Report.pdf> [<https://perma.cc/CV3P-SVJG>]; IBIS REPROD. HEALTH, EVALUATING PRIORITIES: MEASURING WOMEN'S AND CHILDREN'S HEALTH AND WELL-BEING AGAINST ABORTION RESTRICTIONS IN THE STATES, VOLUME II (2017), <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA-Ibis-Evaluating-Priorities-v2.pdf> [<https://perma.cc/XV53-D7JT>]; Marshall Medoff, *Pro-Choice Versus Pro-Life: The Relationship Between State Abortion Policy and Child Well-Being in the United States*, 37 HEALTH CARE WOMEN INT'L 158 (2016).

But how are we to evaluate these choices? While we might evaluate the ways government protects new life in light of some ideal standard of complete or sufficient protection, or by comparison to protection provided by the welfare states of Europe, I have not done so here. Instead, I consider the laws states enact and the policies they fund in light of prevailing American practices. More concretely, *I evaluate the ways a state protects new life by comparing the policy choices a state makes and funds to the policy choices of other state governments in the United States today.*

To make these interstate comparisons, I have employed ranking measures developed by the government and by groups that support and that oppose abortion. For example, to rank jurisdictions that lead in restricting abortion, I have turned to Americans United for Life (AUL), a leading antiabortion organization that crafts model legislation enacted by states opposing abortion.¹⁷ AUL ranks all fifty states on their laws restricting abortion,¹⁸ and thus identifies states that have done the most to enact prolife laws in the nation. The ranking allows us to ask about the policy choices of states that antiabortion advocates affirm as most life protective. To compare how states select and invest in life-protective policies, I have also drawn upon rankings supplied by the Guttmacher Institute¹⁹ and by the U.S. government (e.g., the Centers for Disease Control). (These rankings can of course be contested. I welcome suggestions for additional or substitute policy rankings that might be employed to sharpen the comparisons on which the analysis depends.)

In what follows, I offer some comparisons that illustrate how this inquiry might proceed. My observations are by no means intended as exhaustive. Rather, the object is to demonstrate that *claims about state interest in protecting life can be evaluated in light of facts about the kinds of policies that states enact and fund.*

B. State Interest in Protecting New Life: The Facts

To begin comparing the ways that states protect life, we can ask whether states that restrict abortion help women avoid unwanted pregnancy.

17. See AMS. UNITED FOR LIFE, DEFENDING LIFE 274–306, 312–80 (2017), <http://www.aul.org/wp-content/uploads/2017/03/DefendingLife2017.pdf> [<https://perma.cc/Z92-MLKT>]. AUL drafted the Texas abortion laws that the Supreme Court struck down in *Whole Woman's Health*. Zoë Carpenter, *The Big Lie at the Heart of the Texas Abortion Clinic Case*, NATION (Mar. 1, 2016), <https://www.thenation.com/article/the-big-lie-at-the-heart-of-the-texas-abortion-clinic-case> [<https://perma.cc/W756-GEDP>]; Ian Millhiser, *The Right to Choose Survives! Texas Anti-Abortion Law Struck Down by Supreme Court*, THINKPROGRESS (June 27, 2016, 2:05 PM), <https://thinkprogress.org/the-right-to-choose-survives-texas-anti-abortion-law-struck-down-by-supreme-court-b86960be9936> [<https://perma.cc/WN34-XVHV>].

18. AMS. UNITED FOR LIFE, *supra* note 17, at 21. AUL's top ten states in 2017 are: (1) Oklahoma, (2) Kansas, (3) Louisiana, (4) Arkansas, (5) Arizona, (6) South Dakota, (7) Mississippi, (8) Georgia, (9) Michigan, and (10) Pennsylvania. AUL's bottom ten states are: (1) Washington, (2) California, (3) Vermont, (4) New Jersey, (5) Oregon, (6) Nevada, (7) New York, (8) Connecticut, (9) Massachusetts, and (10) Hawaii. See also AMS. UNITED FOR LIFE, OVERVIEW: 2017 AUL LIFE LIST AND ALL-STARS 3–7 (2017), <http://www.aul.org/wp-content/uploads/2017/01/2017-Life-List-Overview.pdf> [<https://perma.cc/6UHH-6L9L>].

19. See *Guttmacher Policy Review*, GUTTMACHER INST., <https://www.guttmacher.org/gpr> [<https://perma.cc/524W-54C9>]; see also *About Us*, GUTTMACHER INST., <https://www.guttmacher.org/about> [<https://perma.cc/2MGV-PPX9>].

For example, do states that restrict abortion require sex education for students, and if so, does such instruction inform students about contraception?²⁰

AUL ranks Oklahoma first, as having the most restrictive abortion laws in the country.²¹ Despite restricting abortion in this way, Oklahoma does not require its schools to provide sex education,²² even though half of Oklahoma students have had

20. One-third of sexual education classes in the United States are abstinence only, which means the classes teach students to refrain from sexual activity until heterosexual marriage as the sole acceptable form of sexual behavior; these classes include only negative information about birth control and abortion. Cornelia T. Pillard, *Our Other Reproductive Choices: Equality in Sex Education, Contraceptive Access, and Work-Family Policy*, 56 EMORY L.J. 941, 947 (2007). For a more detailed review of abstinence-only programs, see John Santelli et al., *Abstinence-Only-Until-Marriage: An Updated Review of U.S. Policies and Programs and Their Impact*, 61 J. ADOLESCENT HEALTH 273 (2017).

Abstinence only sex education has been shown to not alter sexual behavior. A review of fifty-six sex education studies found that most abstinence-only sex education programs do not alter sexual behavior as compared to no sex education, but that two-thirds of comprehensive programs delay initiation of sex and increase condom and contraceptive use. Douglas B. Kirby, *The Impact of Abstinence and Comprehensive Sex and STD/HIV Education Programs on Adolescent Sexual Behavior*, 5 SEXUALITY RES. & SOC. POL'Y 18 (2008).

There are fewer studies directly addressing the effect of abstinence-only programs on pregnancy rates, but a 2007 study found “comprehensive sex education was associated with a 50% lower risk of teen pregnancy” than abstinence-only sex education. Pamela K. Kohler, Lisa E. Manhart & William E. Lafferty, *Abstinence-Only and Comprehensive Sex Education and the Initiation of Sexual Activity and Teen Pregnancy*, 42 J. ADOLESCENT HEALTH, 344 (2008); see also Kathrin F. Stanger-Hall & David W. Hall, *Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S.*, 6 PLOS ONE e24658 (2011) (finding that in states that did not mention abstinence in their state laws or policies there was an average teen pregnancy rate of fifty-nine pregnancies per 1000 girls aged fourteen through nineteen, and in states that stressed abstinence-only education, the teen pregnancy rate was seventy-three pregnancies per 1000 girls aged fourteen through nineteen). This is consistent with findings that those who take “virginity pledges,” typically public declarations by adolescents to remain abstinent until marriage, increase their risk of nonmarital pregnancy by slightly more than fifty percent. Anthony Paik, Kenneth J. Sanchagrin & Karen Heimer, *Broken Promises: Abstinence Pledging and Sexual and Reproductive Health*, 78 J. MARRIAGE & FAMILY 556 (2016); see also Aaron E. Carroll, *Sex Education Based on Abstinence? There's a Real Absence of Evidence*, N.Y. TIMES (Aug. 22, 2017), <https://www.nytimes.com/2017/08/22/upshot/sex-education-based-on-abstinence-theres-a-real-absence-of-evidence.html> [<https://perma.cc/K4PX-ZHBF>].

Comprehensive sex education is supported by the American Psychological Association, the American Medical Association, and the American Academy of Pediatrics. Jonathon Klein & Committee on Adolescence, *Adolescent Pregnancy: Current Trends and Issues* 2005 PEDIATRICS 281 (2005); AM. MED. ASS'N, H-170.968 SEXUALITY EDUCATION, ABSTINENCE, AND DISTRIBUTION OF CONDOMS IN SCHOOLS (2016); Press Release, American Psychologists Association, Based on the Research, Comprehensive Sex Education is More Effective at Stopping the Spread of HIV Infection, Says APA Committee, (Feb. 23, 2005).

21. See AMS. UNITED FOR LIFE, OVERVIEW: 2017 AUL LIFE LIST AND ALL-STARS, *supra* note 18.

22. *Sex and HIV Education*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education> [<https://perma.cc/9WYF-P7KH>] (last updated Dec. 1, 2017). Only two of AUL's most abortion restrictive states mandate sex education, while six of AUL's least restrictive states do the same. *Id.*

sex and nearly forty percent are sexually active.²³ If schools provide sex education, Oklahoma requires teachers to stress abstinence.²⁴ Unlike the eighteen states that require sex education to cover contraception, Oklahoma, the most abortion-restrictive state in the nation, does not require sexual education classes to teach students about contraception.²⁵

The year that Texas asked the Supreme Court to uphold abortion restrictions closing most of the clinics in the state, a quarter of the state's public school districts offered no sex education at all, and nearly sixty percent used abstinence-only education programs during the same period.²⁶ Texas does not require its schools to educate students about contraception—even though, like Oklahoma, half of high school students are sexually experienced,²⁷ and in 2015 Texas had the fifth-highest teen birth rate in the nation.²⁸

23. In the United States, 46% of all high school age students, and 62% of high school seniors, have had sexual intercourse. CTRS. FOR DISEASE CONTROL & PREVENTION, No. SS-5, YOUTH RISK BEHAVIOR SURVEILLANCE—UNITED STATES, 2009, at 20 (2010), <https://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf> [<https://perma.cc/Q7RG-4A5A>]; see *id.* at 99, 101 (reporting that 51.1% of Oklahoma high school students have “ever had sexual intercourse” and 39.8% of Oklahoma high school students are “currently sexually active,” reporting that in the United States, 46% of all high school age students and 62% of high school seniors have had sexual intercourse, and reporting that states with the highest numbers of students who have had sex before they were thirteen years old are Mississippi, Arkansas, and Alabama); GLADYS MARTINEZ, CASEY E. COPEN & JOYCE C. ABMA, CTRS. FOR DISEASE CONTROL & PREVENTION, TEENAGERS IN THE UNITED STATES: SEXUAL ACTIVITY, CONTRACEPTIVE USE, AND CHILDBEARING, 2006–2010 NATIONAL SURVEY OF FAMILY GROWTH (2011), https://www.cdc.gov/nchs/data/series/sr_23/sr23_031.pdf [<https://perma.cc/Q2FC-C3UK>].

24. OKLA. STAT. ANN. tit. 70, § 11-105.1 (West 2013) (“Such curriculum, materials, classes, programs, tests, surveys or questionnaires shall have as one of its primary purposes the teaching of or informing students about the practice of abstinence.”); *cf.* OKLA. STAT. ANN. tit. 25, § 2003 (West Supp. 2017) (granting parents “[T]he right to opt out of a sex education curriculum if one is provided by the school district.”).

25. *Sex and HIV Education*, *supra* note 22 (reporting that as of December 1, 2017, eighteen states and the District of Columbia require schools that teach sex education to provide information on contraception).

26. Cassandra Pollock, *Study: A Quarter of Texas Public Schools No Longer Teach Sex Ed*, TEX. TRIB. (Feb. 14, 2017, 3:00 PM) (citing TEX. FREEDOM NETWORK EDUC. FUND, CONSPIRACY OF SILENCE: SEXUALITY EDUCATION IN TEXAS PUBLIC SCHOOLS IN 2015–16, <http://a.tfn.org/sex-ed/executive-summary-web.pdf> [<https://perma.cc/MN2J-W4PR>]), <https://www.texastribune.org/2017/02/14/texas-public-schools-largely-teach-abstinence-only-sex-education-repor> [<https://perma.cc/EV35-HLDQ>].

27. Christine Markham, Melissa Peskin, Belinda F. Hernandez, Kimberly Johnson, Robert C. Addy, Paula Cuccaro, Ross Shegog & Susan Tortolero, *Adolescent Sexual Behavior: Examining Data from Texas and the US*, 2 J. APPLIED RES. ON CHILD. 1, 4–5 (2011) (reporting evidence suggesting that a quarter of middle school students and half of high school students are sexually experienced); see also CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 23, at 99 (reporting that 51.6% of Texas high school students have had sex).

28. Pollock, *supra* note 26 (citing UNITED HEALTH FOUND., AMERICA'S HEALTH RANKINGS, 2015 ANNUAL REPORT (2015), <http://www.americashealthrankings.org/explore/2015-annual-report/measure/TeenBirth/state/TX> [<https://perma.cc/G52X-A7Q8>]) (reporting Texas as having the fifth-highest teen birth rate in the nation “with 41 births per 1,000 women

Do states that restrict abortion support women in accessing contraception?

While Texas plays a leading role in restricting abortion, it has one of the worst records in providing access to contraception. Texas ranks forty-seventh among states for meeting the contraception needs of poor women in the state,²⁹ and ranks forty-eighth for general contraception access³⁰—policies that contribute to the state’s high birth rate.³¹ At least one Texas legislator advocates abortion restrictions as a substitute for contraception and as an alternative means of controlling birth. The legislator has proposed a bill allowing prosecutors to charge women and abortion providers with murder, reasoning that the threat of incarceration “would ‘force’ women to be ‘more personally responsible’ with sex” and “would reduce the number of pregnancies ‘when they know that there’s repercussions.’”³²

Texas is not alone in restricting abortion without helping women access effective

aged 15 to 19, according to data from the Centers of Disease Control and Prevention”). For a recent account of value conflicts teen pregnancy presents to communities committed to abstinence, see generally Sheryl Gay Stolberg, *Pregnant at 18. Hailed by Abortion Foes. Punished by Christian School.*, N.Y. TIMES (May 20, 2017), <https://www.nytimes.com/2017/05/20/us/teen-pregnancy-religious-values-christian-school.html> [<https://perma.cc/WM4R-C3HZ>].

29. UNITED HEALTH FOUND., AMERICA’S HEALTH RANKINGS, 2016 HEALTH OF WOMEN AND CHILDREN REPORT (2016), http://www.americashealthrankings.org/explore/2016-health-of-women-and-children-report/measure/Family_planning/state/TX (measuring by the “[p]ercentage of need for contraceptive services by women with a family income 250% below the federal poverty level and women younger than age 20 years is met by publicly-funded providers”).

30. GUTTMACHER INST., CONTRACEPTION COUNTS: RANKING STATE EFFORTS 5 (2006), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/2/23/IB2006n1.pdf> [<https://perma.cc/L7S6-8Y3Z>]; see also *Insurance Coverage of Contraceptives*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives> [<https://perma.cc/ZWU4-PC8E>] (last updated Dec. 1, 2017).

31. Recently, Texas gave up \$35 million a year in Medicaid funds in order to block Planned Parenthood from serving as a Medicaid provider, and in the first eighteen months after the change “thousands of women stopped getting long-acting birth control, and Medicaid pregnancies increased by 27 percent, according to a research paper published last year in *The New England Journal of Medicine*.” Abby Goodnough, *Texas Seeks Medicaid Money It Gave Up Over Planned Parenthood Ban*, N.Y. TIMES (May 15, 2017) (citing Amanda J. Stevenson, Imelda M. Flores-Vazquez, Richard L. Allgeyer, Pete Schenkkan & Joseph E. Potter, *Effect of Removal of Planned Parenthood from the Texas Women’s Health Program*, 374 NEW ENG. J. MED. 853, 856–60 (2016)), <https://www.nytimes.com/2017/05/15/health/texas-medicaid-planned-parenthood.html> [<https://perma.cc/Q5KJ-XV5J>].

32. Lyanne A. Guarecuco, *Lawmaker: Criminalizing Abortion Would Force Women to be ‘More Personally Responsible,’* TEX. OBSERVER (Jan. 23, 2017, 9:00 AM), <https://www.texasobserver.org/texas-lawmaker-no-abortion-access-would-force-women-to-be-more-personally-responsible-with-sex> [<https://perma.cc/5WXE-UGDJ>]. Defending his proposed bill to allow prosecutors to charge women and providers with murder for abortion, State Representative Tony Tinderholt observed:

Right now, it’s real easy. Right now, they don’t make it important to be personally responsible because they know that they have a backup of “oh, I can just go get an abortion.” Now, we both know that consenting adults don’t always think smartly sometimes. But consenting adults need to also consider the repercussions of the sexual relationship that they’re gonna have, which is a child.

Id.

forms of contraception. AUL ranks Louisiana as the third most abortion-restrictive state in the nation.³³ At the same time, Louisiana meets the contraception needs of the smallest percentage of poor women in any state.³⁴ Louisiana has no laws requiring otherwise comprehensive insurance plans to cover contraception, though these contraceptive equity laws are common—twenty-eight states have them.³⁵ Only three states of the ten states that AUL ranks as most restricting access to abortion have contraceptive equity laws, while all ten states that AUL ranks as having the least restrictions on abortion access have contraceptive equity laws.³⁶

As these examples so vividly illustrate, states may restrict access to abortion without taking effective measures to help women avoid pregnancies they do not want.

Do states that restrict abortion help women who want to be mothers maintain their pregnancies?

Let's start with state decision making around health care.

Consider one striking example concerning maternal health care. In 2016, at the time of the Court's decision in *Whole Woman's Health*, pregnancy-related death in Texas was higher than in any other state and the rest of the developed world, a rate that doubled in the period from 2010 to 2014.³⁷ In the midst of this crisis, the state nonetheless decided to cut its family planning budget in 2011 by sixty-six percent,

33. AMS. UNITED FOR LIFE, *supra* note 17.

34. UNITED HEALTH FOUND., *supra* note 29. The United Health Foundation is a nonprofit organization that releases a yearly report, America's Health Rankings, with data from the Centers for Disease Control and Prevention, American Medical Association, Federal Bureau of Investigations, Dartmouth Atlas Project, U.S. Department of Education, and the U.S. Census Bureau.

35. *Insurance Coverage of Contraceptives*, *supra* note 30 (documenting that twenty-eight states, but not Louisiana, require insurers that cover prescription drugs to provide coverage of FDA-approved prescription contraceptive drugs and devices). State contraceptive equity laws are only partly superseded by federal health insurance law (they apply even if an insurance plan is grandfathered under the Affordable Care Act's contraceptive mandate) and will continue to mandate the inclusion of contraceptive coverage in health insurance plans, even if the Trump administration rolls back federal requirements. See Exec. Order No. 13,798, 82 Fed. Reg. 21675 (May 9, 2017); *Contraceptive Equity Laws in Your State: Know Your Rights—Use Your Rights, A Consumer Guide*, NAT'L WOMEN'S L. CTR. (Aug. 27, 2012), <https://nwlc.org/resources/contraceptive-equity-laws-your-state-know-your-rights-use-your-rights-consumer-guide> [<https://perma.cc/UH5N-AGJ6>].

36. *Insurance Coverage of Contraceptives*, *supra* note 30 (documenting that Arkansas, Arizona, and Michigan (AUL top ten states) require coverage, as do Washington, California, Vermont, New Jersey, Oregon, Nevada, New York, Connecticut, Massachusetts, and Hawaii (AUL bottom ten states)).

37. Molly Redden, *Texas has Highest Maternal Mortality Rate in Developed World, Study Finds*, GUARDIAN (Aug. 20, 2016, 7:00 AM) (citing Marian F. MacDorman, Eugene Declercq, Howard Cabral & Christine Morton, *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 OBSTETRICS & GYNECOLOGY 447–55 (2016)), <https://www.theguardian.com/us-news/2016/aug/20/texas-maternal-mortality-rate-health-clinics-funding> [<https://perma.cc/J5FH-6RCA>]. See generally Nicholas Kristof, *If Americans Love Moms, Why Do We Let Them Die?*, N.Y. TIMES (July 29, 2017), <https://www.nytimes.com/2017/07/29/opinion/sunday/texas-childbirth-maternal-mortality.html> [<https://perma.cc/M8HQ-WMJ7>] (observing that an “American woman is about five times as likely to die in pregnancy or childbirth as a British woman” and that “in Texas, women die from pregnancy at a rate almost unrivaled in the industrialized world”).

forcing many clinics that provide OB-GYN care, contraception, and checkups for pregnant women to shut down.³⁸ Twenty-eight percent of Texas women of childbearing age do not have health insurance, and Texas has not chosen to expand Medicaid to help close this gap.³⁹ Texas has also forgone Medicaid family planning funds, and instead set up its own women's health program to allow the state to withhold funding from Planned Parenthood and other clinics associated with abortion providers.⁴⁰ A Texas Representative explained, "Well of course this is a war on birth control and abortions and everything—that's what family planning is supposed to be about."⁴¹ Texas asks new mothers and their infants to pay the health care costs of the state's antagonism toward abortion.

Texas is not alone. Many states that lead in policies hostile to abortion lag in indicators of health and in policies providing access to health care. The ten states that AUL identifies as most restricting access to abortion have an average maternal mortality rate of 26.4 per 100,000 births, while the ten states AUL ranked least abortion restrictive have a maternal mortality rate of 14.8.⁴² The ten states that AUL ranked most abortion restrictive have an average infant mortality rate of 7.1 per 1000 births, while the ten states that AUL ranked least abortion restrictive have an average infant mortality rate of 4.9 per 1000 births.⁴³ Yet of the ten states that AUL identifies as most restricting access to abortion, five have refused to expand Medicaid for low-income

38. The 2011 Texas defunding was a sixty-six percent cut to family-planning grants that led eighty-two clinics to close, one-third of which were Planned Parenthood affiliates. Deborah Netburn, *After Texas Stopped Funding Planned Parenthood, Low-Income Women Had More Babies*, L.A. TIMES (Feb. 3, 2016, 4:01 PM), <http://www.latimes.com/science/sciencenow/la-sci-sn-planned-parenthood-texas-births-20160203-story.html> [https://perma.cc/93BD-QXRH]; Redden, *supra* note 37.

39. Jessica Belasco, *Behind from the Start: Why Some Women Aren't Receiving Early Prenatal Care*, SAN ANTONIO EXPRESS-NEWS (Jan. 9, 2016, 11:16 AM), <https://social.shorthand.com/ExpressNews/ngoGWvemOf/behind-from-the-start> [https://perma.cc/6EXB-3ZHG].

40. Netburn, *supra* note 38; see also Wade Goodwyn, *Gov. Perry Cut Funds for Women's Health in Texas*, NPR (Sept. 20, 2011, 12:01 AM), <http://www.npr.org/2011/09/20/140449957/gov-perry-cut-funds-for-womens-health-in-texas> [https://perma.cc/C66P-5WA4] ("Family planning clinics are routinely referred to by many Texas Republican legislators as 'abortion clinics' even though none of the 71 family planning clinics in the state that receive government funding provides abortions. Texas and federal law prohibits that, but most women's health clinics will refer women or teens who want an abortion to a provider.").

41. Goodwyn, *supra* note 40.

42. The AUL least restrictive states include Vermont, which does not have reported data, so the average rate for the AUL least restrictive states is based on nine states, not ten. UNITED HEALTH FOUND., AM.'S HEALTH RANKINGS, 2016 HEALTH OF WOMEN AND CHILDREN REPORT (2016), http://www.americahealthrankings.org/explore/2016-health-of-women-and-children-report/measure/maternal_mortality/state/ALL [https://perma.cc/RDR6-TQMU] (defining maternal mortality as the "[n]umber of deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within forty-two days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 births"). The average mortality rate in the United States is 19.9 maternal deaths per 100,000 births. *Id.*

43. *Infant Mortality Rates by State, 2015*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 4, 2017), https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm [https://perma.cc/9WR7-NWCY].

families, while of the ten states AUL ranked as least abortion restrictive, *none* have refused the Medicaid expansion for low-income families.⁴⁴

Now let's bring financial considerations into the frame.

When women are asked about their reasons for deciding to end a pregnancy, forty percent or more cite financial reasons.⁴⁵ There is a reason that women who chose abortion have financial concerns: forty-nine percent of the women who choose to end pregnancies live below the federal poverty level, and seventy-five percent are poor or low income.⁴⁶ Yet, we often debate the constitutionality and the politics of abortion restrictions as if the question has no connection to women's resources. *None of the abortion policies advocated for by AUL provide resources, health care, or job protection to pregnant women or infants.*⁴⁷ Four of AUL's top ten states have "Family Caps": they refuse to provide public assistance to support a child born to a family already receiving public assistance.⁴⁸ (Antiabortion advocates may support

44. *A 50-State Look at Medicaid Expansion*, FAMILIES USA, (Apr. 2017), <http://familiesusa.org/product/50-state-look-medicaid-expansion> [<https://perma.cc/3XR5-35AV>].

45. M. Antonia Biggs, Heather Gould & Diane Greene Foster, *Understanding Why Women Seek Abortions in the US*, 13 BMC WOMEN'S HEALTH 29, 33 (2013) (employing data collected from 2008 to 2010); cf. Lawrence B. Finer, Lori F. Frohworth, Lindsay A. Dauphinee, Susheela Singh & Ann M. Moore, *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 110, 113–18 (2005) (describing a study that employed different questions and data from 2004 and found that seventy-three percent of women reported having an abortion because they could not afford having a baby).

46. *United States Abortion Demographics*, GUTTMACHER INST., <https://www.guttmacher.org/united-states/abortion/demographics> [<https://perma.cc/7PWC-2GVG>].

47. AUL has the following classes of legislation: The Women's Protection Project (informed consent, coercion, parental consent, clinic health standards, rape reporting, and a law stating women should be told that "drug-induced abortions can be reversed"); The Infants Protection Project (fetal remains, partial-birth abortion bans, sex-selection/abnormality laws); Defunding Abortion Providers; Other Abortion Legislation (additional parental consent, honoring of Crisis Pregnancy Centers); Legal Recognition and Protection of the Unborn (fetal protection outside the abortion context); Bioethics and Biotechnologies; End-of-Life; and Healthcare Freedom of Conscience. *AUL's 2017 Model Legislation & Policy Guides*, AM. UNITED FOR LIFE, <http://www.aul.org/auls-2017-model-legislation-policy-guides> [<https://perma.cc/XXZ8-JWMN>]. Similarly, the National Right to Life does not have any legislation that would provide resources or care to pregnant women. *State Legislative Center*, NAT'L RIGHT TO LIFE, <http://www.nrlc.org/statelegislation> [<https://perma.cc/TW54-ZLZS>]; see also *Federal Legislation*, NAT'L. RIGHT TO LIFE, <http://www.nrlc.org/federal> [<https://perma.cc/F69T-WAG2>]. Also perhaps worth noting is AUL's proposed state constitutional amendment with the following first section: "The policy of [Insert name of State] is to protect the life of every unborn child from conception to birth, to the extent permitted by the federal constitution." AMS. UNITED FOR LIFE, *STATE CONSTITUTIONAL AMENDMENT: MODEL LEGISLATION & POLICY GUIDE FOR THE 2017 LEGISLATIVE YEAR* (2016) (emphasis in original), <http://www.aul.org/downloads/2017-Legislative-Guides/Abortion/StateConstitutionalAmendment2017LG.pdf> [<https://perma.cc/E46X-9CJM>]. While this definition of protecting potential life thus explicitly states that the protection ends at birth, it also seems to commit the state to taking life-protective action outside the abortion context, as well as in it. *Id.* A constitutional commitment to protecting unborn children could require ensuring that pregnant women have access to prenatal healthcare as well as the financial and other resources they need to develop a healthy fetus.

48. CTR. ON REPROD. RIGHTS & JUSTICE, BERKELEY LAW, BRINGING FAMILIES OUT OF

adoption, rather than public assistance, on the view that “welfare causes more crisis pregnancies. By making single-parent households possible, welfare dollars remove the stigma of sex and pregnancy outside marriage.”⁴⁹

In the United States, women who need to support themselves and their families have reason to be concerned about becoming pregnant. Thirty-eight percent of women report that they decided to end a pregnancy because a pregnancy would interfere with their job, employment, or career.⁵⁰ The fear is well founded. Even with the protections of federal laws such as the Pregnancy Discrimination Act⁵¹ and the Family and Medical Leave Act,⁵² pregnant women lose their jobs at a significant rate.⁵³ Nearly one-third of the claims alleging discriminatory discharge filed at the Equal Employment Opportunity Commission (EEOC) were filed by women alleging they were discharged for becoming pregnant. Many pregnant women alleged their employers refused minor job modifications they needed to keep working.⁵⁴

Do states that restrict abortion help pregnant workers keep their jobs by enacting laws that increase protections over the federal baseline?

Louisiana is the only AUL top ten state to enact a pregnant worker fairness act⁵⁵ requiring employers to make reasonable accommodations that would allow pregnant

‘CAP’TIVITY: THE PATH TOWARD ABOLISHING WELFARE FAMILY CAPS (2016), https://www.law.berkeley.edu/wp-content/uploads/2015/04/2016-Caps_FA2.pdf [<https://perma.cc/AN5B-3LLN>].

49. Frederica Mathewes-Green, *Pro-Life Dilemma: Pregnancy Centers and the Welfare Trap*, 78 POL’Y REV. 40, 40–41 (1996); see also Goodwyn, *supra* note 40 (discussing crisis pregnancy centers “for women who are willing to keep their babies or give them up for adoption” and quoting a clinic president in Texas who reports that “only 1 to 2 percent [of pregnant women at the crisis pregnancy center] are willing to let their babies be adopted, and object that ‘I’d rather abort than give my baby up for adoption’”); Reva B. Siegel, *The Right’s Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1678–79, 1678 n.122 (2008) (discussing support for adoption among antiabortion advocates concerned to promote the traditional family and concerned that public assistance enables family formation outside marriage).

50. See Finer et al., *supra* note 45, at 113.

51. Pregnancy Discrimination Act of 1978, 42 U.S.C. § 2000e (2012).

52. Family and Medical Leave Act (FMLA) of 1993, 29 U.S.C. § 2601 (2012).

53. See NAT’L P’SHP FOR WOMEN & FAMILIES, BY THE NUMBERS: WOMEN CONTINUE TO FACE PREGNANCY DISCRIMINATION IN THE WORKPLACE: AN ANALYSIS OF U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION CHARGES (FISCAL YEARS 2011–2015) (2016), <http://www.nationalpartnership.org/research-library/workplace-fairness/pregnancy-discrimination/by-the-numbers-women-continue-to-face-pregnancy-discrimination-in-the-workplace.pdf> [<https://perma.cc/57PV-K643>] (analyzing the nearly 31,000 claims of pregnancy discrimination filed with the EEOC and state-level fair employment agencies between October 2011 and September 2015).

54. *Id.* (documenting the more than 650 charges by women alleging they were not provided the reasonable workplace accommodations they needed between October 2014 and September 2015).

55. Texts of pregnant worker fairness acts (PWFA) vary, but the California PWFA is typical:

It shall be an unlawful employment practice, unless based upon a bona fide occupational qualification: (a) For an employer to refuse to allow a female employee disabled by pregnancy, childbirth, or related medical condition to take a leave for a reasonable period of time not to exceed four months and thereafter return to work, as set forth in the commission’s regulations. The employee shall

workers to keep their jobs; by contrast, six of AUL's bottom ten states have pregnant worker fairness acts.⁵⁶

None of AUL's top ten states have laws expanding family leave coverage beyond federal standards, while *eight* out of the bottom ten states do.⁵⁷ Three of the bottom ten states have enacted paid family leave.⁵⁸

These policy differences are striking. As we have seen, large numbers of women

be entitled to utilize any accrued vacation leave during this period of time. Reasonable period of time means that period during which the female employee is disabled on account of pregnancy, childbirth, or a related medical condition . . . (b)(1) For an employer to refuse to provide reasonable accommodation for an employee for conditions related to pregnancy, childbirth, or related medical conditions, if she so requests, with the advice of her health care provider. (2) For an employer who has a policy, practice, or collective bargaining agreement requiring or authorizing the transfer of temporarily disabled employees to less strenuous or hazardous positions for the duration of the disability to refuse to transfer a pregnant female employee who so requests. (3) For an employer to refuse to temporarily transfer a pregnant female employee to a less strenuous or hazardous position for the duration of her pregnancy if she so requests, with the advice of her physician, where that transfer can be reasonably accommodated. However, no employer shall be required by this section to create additional employment that the employer would not otherwise have created, nor shall the employer be required to discharge any employee, transfer any employee with more seniority, or promote any employee who is not qualified to perform the job.

CAL. GOV'T CODE § 12945(a)(1), (a)(3)(A)–(C) (West 2011).

56. Louisiana's PWFA applies to businesses with twenty-five or more employees. A BETTER BALANCE, PREGNANCY PROTECTIONS FOR WORKERS IN STATES AND LOCALITIES ACROSS THE U.S. (2017), <http://www.abetterbalance.org/resources/fact-sheet-state-and-local-pregnant-worker-fairness-laws> [<https://perma.cc/UKB5-G26E>]; see also Marsha Mercer, *States Go Beyond Federal Law to Protect Pregnant Workers*, PEW CHARITABLE TR. (Jan. 7, 2015), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/1/07/states-go-beyond-federal-law-to-protect-pregnant-workers> [<https://perma.cc/NAN9-FH6J>] ("Texas does not have a statewide law covering private employers, but since 2001 it has required county and municipal governments to make reasonable efforts to accommodate their pregnant employees."); Bob Salsberg, *Protection for Pregnant Workers Bill Signed in Massachusetts*, U.S. NEWS (July 27, 2017, 5:27 PM), <https://www.usnews.com/news/best-states/massachusetts/articles/2017-07-27/gov-baker-planning-to-sign-pregnant-worker-protection-bill>.

57. California, Connecticut, the District of Columbia, Hawaii, Maine, Minnesota, New Jersey, Oregon, Rhode Island, Vermont, Washington, and Wisconsin have state family leave laws, most of which have expanded either the amount of leave available or the classes of persons for whom leave may be taken beyond the federal Family and Medical Leave Act, which provides up to twelve weeks of unpaid leave during a twelve month period to care for a newborn, adopted or foster child, to care for a family member, or to attend to the employee's own serious medical health condition. Only three states—California, New Jersey, and Rhode Island—currently offer paid family and medical leave. New York will join them effective January 1, 2018, after passing the Paid Family Leave Benefits Law during the 2016 session. *State and Family Medical Leave Laws*, NAT'L CONF. ST. LEGISLATURES (July 19, 2016), <http://www.ncsl.org/research/labor-and-employment/state-family-and-medical-leave-laws.aspx> [<https://perma.cc/C8P5-JAYY>].

58. California and New Jersey have paid family leave laws. New York passed a paid family leave law on April 4, 2016, which will take effect January 1, 2018. *Id.* at 2–5.

who choose abortion are poor and end pregnancies as a way of preserving scant resources to support themselves and their families. Opponents of abortion may oppose providing these women public resources that would enable them to continue a wanted pregnancy, on the ground that it would sanction or support sex out of wedlock, or alternately in the fear that it might increase abortion rates.⁵⁹ Yet concerns about extramarital sex and out-of-wedlock birth do not explain refusal to improve the job security of pregnant workers, a strategy for deterring abortion, which helps pregnant women support themselves and their families.

II. PROLIFE? LOCATING ABORTION RESTRICTIONS IN A PROCHOICELIFE FRAMEWORK

In conversations about abortion it is commonly assumed that those who would restrict abortion do so for benign reasons, out of concern to protect unborn life. But expanding the frame and considering the policy choices of some abortion-restrictive states calls that assumption into question. The facts we have considered show that many presuppositions, motives, and values shape the ways states protect life.

Some state legislatures may protect life consistently across contexts, in ways that support women's reproductive choices and in ways that limit them. But as we have seen, a number of prolife jurisdictions do something quite different: *they lead in protecting life in ways that restrict women's reproductive choices, and they lag in protecting life in ways that support women's reproductive choices.*

If a legislature's principle and goal is to protect new life, why not protect life in ways that support, as well as restrict, women's reproductive choices? Assuming those who are committed to protecting life are also committed to protecting liberty and equality, why not protect new life in ways that enhance, as well as restrict, women's agency? In fact, why not protect new life in ways that support women's reproductive choices *before* protecting new life in ways that oppose women's reproductive choices?

There are at least two ways to explain the policy choices of many traditional prolife legislators and legislatures sampled above. First, attitudes about gender and sexuality may shape the ways a state protects life. Some legislators may oppose abortion without protecting new life outside the abortion context (for example, by

59. See Mathewes-Green, *supra* note 49 (discussing antiabortion advocates who promote adoption rather than provide public assistance in order to manage abortion in ways that support marriage). For studies probing whether providing welfare increases abortion, see, for example, JOSEPH WRIGHT, CATHOLICS IN ALL. FOR THE COMMON GOOD, REDUCING ABORTION IN AMERICA: THE EFFECT OF SOCIOECONOMIC FACTORS (2008) (finding that economic assistance to low-income families contributed to the reduced number of abortions in the 1990s); Gregory ACS, *The Impact of Welfare on Young Mothers' Subsequent Childbearing Decisions*, 31 J. HUM. RESOURCES 898, 898 (1996) (finding that variations in welfare benefit levels have no statistically "significant impacts on subsequent childbearing decisions of young mothers"); Laura S. Hussey, *Is Welfare Pro-Life? Assistance Programs, Abortion, and the Moderating Role of States*, 85 SOC. SERV. REV. 75, 75 (2011) (finding "that welfare recipients are substantially less likely to turn to abortion than are comparable low-income pregnant women but that this is only true of recipients in states where abortion policies, access to abortion providers, and public opinion reflect a pro-life orientation").

providing health care to women who seek to bring a pregnancy to term).⁶⁰ In these cases, opposition to abortion reflects judgments about women who have sex and refuse motherhood, reflecting an interest in controlling women's choices rather than a general concern to protect new life. In the nineteenth century, when abortion was first criminalized, concerns about regulating sex and preserving marital roles were widely cited as reasons for restricting abortion.⁶¹ Similar concerns persist today. In 2016, the Republican Party's platform explained that the party wants to appoint judges who demonstrate respect for "traditional family values and the sanctity of innocent human life."⁶² This platform plank, which has been repeated since Ronald Reagan's election in 1980,⁶³ openly blends concern about preserving traditional family structures with concerns about protecting life as reasons for restricting abortion.⁶⁴

But perhaps the explanation for the apparently inconsistent ways many traditionally prolife jurisdictions protect life lies elsewhere. Attitudes about private property, rather than gender and sexuality, may explain a state's choice of means to protect life. Differently put, conservatives may oppose the expansion of Medicaid because they are hostile to redistribution and are committed to a limited state. One should not forget that the American antiabortion movement came to political prominence as part of the New Right insurgency in the Republican Party that elected Ronald

60. For examples of legislators who condemn abortion yet oppose providing health care to pregnant women, see *infra* Part III.B (discussing Representative Shimkus).

61. Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 280–322 (1992).

62. For the Republican Party platforms, see REPUBLICAN NAT'L CONVENTION, REPUBLICAN PLATFORM 2016 (2016), http://www.presidency.ucsb.edu/papers_pdf/117718.pdf [<https://perma.cc/WG2Q-EJ6B>]. Protestants and Catholics condemn the "contraceptive mentality." See Douglas NeJaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2546 n.120 (2015) (citing *Bishop Burke on the Dignity of Human Life and Civic Responsibility*, ZENIT (Jan. 10, 2004), <http://www.zenit.org/en/articles/bishop-burke-on-the-dignity-of-human-life-and-civic-responsibility> [<https://perma.cc/V36R-ZQQT>] (printing a pastoral letter from Bishop Raymond Burke of Wisconsin, stating: "The port of entry for the culture of death in our society has been the abandonment of the respect for the procreative meaning of the conjugal act. It is the contraceptive way of thinking, the fear of the life-giving dimension of conjugal love, which very much sustains that culture.")); R. Albert Mohler, Jr., *Can Christians Use Birth Control?*, CHRISTIAN POST (June 6, 2012, 8:19 AM), <http://www.christianpost.com/news/can-christians-use-birth-control-76132> [<https://perma.cc/WJ4W-Q6FY>] ("[W]e must start with a rejection of the contraceptive mentality that sees pregnancy and children as impositions to be avoided rather than as gifts to be received, loved, and nurtured. This contraceptive mentality is an insidious attack upon God's glory in creation, and the Creator's gift of procreation to the married couple.").

63. See *Republican Party Platform of 1980*, AM. PRESIDENCY PROJECT (July 15, 1980), <http://www.presidency.ucsb.edu/ws/index.php?pid=25844> [<https://perma.cc/P9VE-RTG5>].

64. It is because opponents of abortion are concerned to protect traditional family structures that the movement travels under the banner of profamily and couples opposition to abortion with opposition to same-sex marriage. See Robert Post & Reva Siegel, *Roe Rage: Democratic Constitutionalism and Backlash*, 42 HARV. C.R.-C. L. REV. 373, 418–23 (2007) (discussing how the fight over abortion became entangled with the fight over women's liberation and the Equal Rights Amendment); NeJaime & Siegel, *supra* note 62, at 2545–47 (observing movement connections that tie opposition to same-sex marriage, abortion, and contraception as practices that "divert sex and marriage from procreative ends").

Reagan.⁶⁵ On this second model, abortion restrictions are how the neoliberal state protects life.⁶⁶

But if legislators who support abortion restrictions are neoliberals, it is not clear why they would select decisions about abortion for collective determination, override a pregnant woman's decisions, and pressure her to give birth without ensuring that the collective bears the cost of that imposition. If the interest in protecting unborn life is different and as strong as opponents of abortion claim, then why doesn't this policy trump concerns about preserving small government and an unencumbered market? If it is not, then prolife traditionalists are in fact asking women to sacrifice their lives, health, families, resources, and careers for the care of children in ways that the rest of the community will not. In these circumstances, the explanation from private property can loop back into the explanation from sex roles.

III. PROCHOICELIFE: HOW EXPANDING THE FRAME CHANGES THE DEBATE IN LAW AND POLITICS

Consider how states rank in protecting life through sexual education, contraception, abortion, health care, and job protections for pregnant women. If a state protects life selectively—leading states in policies that restrict women's reproductive choices but trailing states in policies that support women's reproductive choices—is that

65. See LINDA GREENHOUSE & REVA B. SIEGEL, BEFORE *ROE V. WADE*: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 294–99, 313–15 (2d ed. 2012); see also DANIEL K. WILLIAMS, DEFENDERS OF THE UNBORN: THE PRO-LIFE MOVEMENT BEFORE *ROE V. WADE* 230–42 (2016); MARY ZIEGLER, AFTER *ROE*: THE LOST HISTORY OF THE ABORTION DEBATE 12–15 (2015).

66. Neoliberalism “is an agenda that promotes not just the withdrawal of the state from market regulation, but the establishment of market-friendly mechanisms and incentives to organize a wide range of economic, social and political activity.” Rajesh Venugopal, *Neoliberalism as Concept*, 44 ECON. & SOC'Y 165, 172 (2015). Minimal state intervention in economic and social affairs and a commitment to free trade and free movement of capital are critical to neoliberal policy. Nicola Smith, *Neoliberalism*, ENCYCLOPEDIA BRITANNICA (July 10, 2017), <https://www.britannica.com/topic/neoliberalism> [<https://perma.cc/G2DP-E6LG>]. David Grewal and Jedediah Purdy focus on the role of law in neoliberalism:

Neoliberal claims serve to protect and expand market imperatives in a persistent political conflict between those imperatives and countervailing democratic demands for values such as security, dignity, fairness, and solidarity. Our definition of neoliberalism helps to tie together various public- and private-law areas by showing how market and democratic imperatives are in conflict there, and how law is mediating those conflicts.

David Singh Grewal & Jedediah Purdy, *Introduction: Law and Neoliberalism*, 77 LAW & CONTEMP. PROBS. 1 (2014). For an account of neoliberalism and the family see Anne L. Alstott, *Neoliberalism in U.S. Family Law: Negative Liberty and Laissez-Faire Markets in the Minimal State*, 77 LAW & CONTEMP. PROBS. 25 (2014) (“Despite [] negative rights against the state, individuals have no positive rights at all to the resources they need to conduct family life. . . . The Supreme Court's rejection of a positive right to state support reflects the . . . neoliberal ideal that dominates U.S. family law: the primacy of resource allocations produced by laissez-faire markets.”). For a rich expression of neoliberal instincts in the organization of health care, see *infra* Part III.B (discussing the Republican Party's opposition to law requiring health care policies to cover pregnancy).

state's policy entitled to the same deference owed a state that protects new life consistently across contexts? This question reverberates with implications for law, politics, and ethics.

Where a state protects life selectively—favoring policies that restrict women's reproductive choices over policies that support women's reproductive choices—that state is in a much weaker position to claim that abortion restrictions vindicate the state's interest in protecting life. In these circumstances, abortion restrictions are more plausibly explained as constitutionally suspect measures designed to control women's roles as mothers.

Where states invest in protecting life by choice-respecting means, abortion restrictions are more plausibly viewed as protecting life, and it is reasonable to ask when and how the state can vindicate this interest in ways that respect women's liberty and equality.

A. Prochoicelife in Law

This basic framework has implications for constitutional law. At the simplest level, it clarifies that in deciding the constitutionality of abortion restrictions, judges need not defer to claims about a state's interest in protecting life as if it were a simple pleading requirement that could be asserted without demonstration that the state is in fact seriously committed to this end.

Rather than defer to a claim that a state is restricting abortion out of concern to protect potential life, a judge can expand the frame and examine the state's policies outside the abortion context. A state's interest in restricting abortion to protect potential life deserves less weight/deference if the state singles out abortion for restriction and does comparatively little to protect unborn life by choice-respecting means.

*Whole Woman's Health*⁶⁷ models scrutiny of this kind. In *Whole Woman's Health*, Texas claimed it was restricting abortion to protect women's health.⁶⁸ Rather than defer to the state's claim about the interests justifying the restriction on abortion, the Court compared how the state regulated in the interests of women's health inside and outside the abortion context. In determining the benefits of the restriction, the Supreme Court took account of the state's decision to single out abortion for onerous health regulation that the state did not impose on medical procedures of equal or greater risk:

Nationwide, childbirth is fourteen times more likely than abortion to result in death, but Texas law allows a midwife to oversee childbirth in the patient's own home. Colonoscopy, a procedure that typically takes place outside a hospital (or surgical center) setting, has a mortality rate ten times higher than an abortion (the mortality rate for liposuction, another outpatient procedure, is twenty-eight times higher than the mortality rate for abortion). Medical treatment after an incomplete miscarriage often involves a procedure identical to that involved in a nonmedical abortion, but it often takes place outside a hospital or

67. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

68. See, e.g., *id.* at 2311.

surgical center. And Texas partly or wholly grandfathered (or waives the surgical-center requirement for) about two-thirds of the facilities to which the surgical-center standards apply. But it neither grandfathered nor provides waivers for any of the facilities that perform abortions. These facts indicate that the surgical-center provision imposes “a requirement that simply is not based on differences” between abortion and other surgical procedures “that are reasonably related to” preserving women’s health, the asserted “purpos[e] of the Act in which it is found.”⁶⁹

Because Texas singled out abortion for health regulation that it did not impose on procedures of equal or greater risk,⁷⁰ the Court questioned whether the restriction served the claimed interest and reduced the weight it was accorded in the *Casey* balance.⁷¹ “We agree with the District Court that the surgical-center requirement, like the admitting-privileges requirement, provides few, if any, health benefits for women, poses a substantial obstacle to women seeking abortions, and constitutes an ‘undue burden’ on their constitutional right to do so.”⁷²

Whole Woman’s Health scrutinized states that singled out abortion restrictions as a means of protecting women’s health. Following *Whole Woman’s Health*, courts can scrutinize states that single out abortion restrictions as a means of protecting potential life. A district court in Texas has done just this. Soon after the Supreme Court struck down Texas’s health-justified restrictions on abortion, the state adopted regulations requiring health clinics to bury or cremate embryonic and fetal tissue.⁷³ The state initially justified the fetal tissue regulation as promoting public health and safety, then as preventing the spread of disease, and finally as protecting public health in ways that “respect life and the dignity of the unborn.”⁷⁴ (The fetal remains law once again places Texas at the frontiers of prolife politics: AUL is now urging the enactment of its Unborn Infants Dignity Act⁷⁵ and laws mandating interment—or what one commentator terms “funerals for fetuses”—are appearing in Indiana, Louisiana, and Ohio.)⁷⁶

69. *Id.* at 2315 (citations omitted).

70. See generally Linda Greenhouse & Reva B. Siegel, *Casey and the Clinic Closings: When “Protecting Health” Obstructs Choice*, 125 YALE L.J. 1428, 1446–49 (2016) (discussing abortion exceptionalism and targeted restrictions of abortion providers under *Casey*); Linda Greenhouse & Reva B. Siegel, *The Difference a Whole Woman Makes: Protection for the Abortion Right After Whole Woman’s Health*, 126 YALE L.J. F. 149 (2016) [hereinafter Greenhouse & Siegel, *The Difference a Whole Woman Makes*].

71. On the *Casey* balance, see *Whole Woman’s Health*, 136 S. Ct. at 2309 (“The rule announced in *Casey* . . . requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer.”).

72. *Id.* at 2318.

73. 25 TEX. ADMIN. CODE. §§ 1.132–1.136 (2017); see also *Whole Woman’s Health v. Hellerstedt (Whole Woman’s Health II)*, 231 F. Supp. 3d 218, 221–22 (W.D. Tex. 2017).

74. *Whole Woman’s Health II*, 231 F. Supp. 3d at 224–25.

75. AMS. UNITED FOR LIFE, UNBORN INFANTS DIGNITY ACT: MODEL LEGISLATION & POLICY GUIDE FOR THE 2016 LEGISLATIVE YEAR (2015), <http://www.aul.org/wp-content/uploads/2015/08/AUL-Unborn-Infants-Dignity-Act-2016-LG-FINAL-8-05-16.pdf> [https://perma.cc/J7WD-98Y6].

76. Rebecca Grant, *The Latest Anti-Abortion Trend? Mandatory Funerals for Fetuses*,

The district court preliminarily enjoined Texas's fetal remains regulation.⁷⁷ In this case (*Whole Woman's Health II*), Judge Sparks questioned whether the state had an interest in protecting potential life after abortion "when there is no potential life to protect."⁷⁸ (A regulation might vindicate the interest in these circumstances, if the regulation dissuades women from ending a pregnancy by constitutionally permissible means.) More significantly for our purposes, Judge Sparks questioned whether the state's inconsistent conduct called into question its asserted interest in restricting abortion to protect potential life.

The district court pointed out that since 1989, Texas regulated the disposal by health care facilities of all human tissue, whether from surgery, autopsy, or an abortion in the same manner, and allowed health care providers to use any one of seven methods, all of which insured sanitary disposal of human tissue.⁷⁹ The challenged regulations, however, single out "fetal tissue" from all other human tissue and limit its disposal to one of three methods, all of which involve some sort of "interment."⁸⁰ The regulations further single out abortion providers by exempting from the new regulations "fetal tissue that is expelled or removed from the human body once the person is outside of a health care facility."⁸¹ As the court noted, Texas "does not offer any reason why fetal tissue must be treated differently at home compared to in a doctor's office."⁸²

Weighing these factors, the court held that the State's "inconsistency [in regulating human remains] reduces the strength of the asserted benefit."⁸³ The court took the state's inconsistencies in regulating human remains into account as it applied the undue burden test of *Casey* and *Whole Woman's Health II*:

It is reasonable to conclude the burdens on abortion exceed any benefit. On one side of the equation DSHS has placed its weak purported benefit of protecting the dignity of the unborn, and on the other side Plaintiffs have placed evidence the Amendments increase costs for healthcare providers, enhance the stigma on women associated with miscarriage and abortion care, and create potentially devastating logistical challenges for abortion providers throughout Texas.⁸⁴

The court also drew inferences about the state's purposes from its inconsistent treatment of the disposal of human remains. The court observed that Texas's "stated interest is a pretext for [the State's] true purpose, restricting abortions," pointing out that in initially drafting and justifying the regulation, the state had repeatedly singled out abortion while "[o]ther medical situations producing fetal

NATION (Oct. 11, 2016), <https://www.thenation.com/article/the-latest-anti-abortion-trend-mandatory-funerals-for-fetuses> [<https://perma.cc/T784-B7M6>].

77. *Whole Woman's Health II*, 231 F. Supp. 3d at 233.

78. *Id.* at 229.

79. *Id.* at 233.

80. *Id.* at 224.

81. *Id.*

82. *Id.* at 230.

83. *Id.*

84. *Id.* at 232.

tissue, such as miscarriages or ectopic pregnancy surgeries, were not considered.”⁸⁵

Thus, in *Whole Woman's Health*, the Supreme Court employed evidence of singling out abortion in determining how a law advanced the state's interest in protecting women's health, and in *Whole Woman's Health II*, Judge Sparks employed evidence of singling out abortion in determining how a law advanced the state's interest in protecting potential life.⁸⁶

Judge Sparks demonstrates selectivity in Texas's initial focus on the interment of fetal tissue from abortions, but not from miscarriages and ectopic pregnancy. But this was not the only respect in which the state was selective in protecting potential life.

If we expand the frame and consider the many ways the state could have protected potential life—either by preventing unwanted pregnancies or supporting wanted pregnancies—we can more precisely describe how the state chose to protect potential life. Texas did not mandate sexual education covering contraception. Texas did not increase access to contraception. Texas did not increase health care for pregnant women. Texas did not increase the job security of pregnant women. The state did not protect potential life by helping women avoid unwanted pregnancies or by supporting women with wanted pregnancies. Instead the state chose to protect potential life by shaming and intimidating and stigmatizing women seeking to end a pregnancy.

As we have seen, Texas lags behind other states in providing sexually active teens education about contraception, in providing women access to effective contraception, in providing women health care, and in providing pregnant women job security.⁸⁷ In our federated system, the state is free to make these policy choices, which reflect the distinctive ways that Texans reason about the regulation of sex and the redistribution of property. But we should be clear that Texas is protecting potential life in ways that other states do not—in ways that reflect this state's distinctive views about women and property. These state choices shape both

85. *Whole Woman's Health II*, 231 F. Supp. 3d 218, 229 (W.D. Tex. 2017).

86. While Judge Sparks invokes evidence of abortion exceptionalism in Texas to suggest that the state's interest in protecting potential life might be a pretext for restricting abortions, the Supreme Court's opinion in *Whole Woman's Health* employs evidence of singling out abortion providers to question the benefit of a restriction without expressly alleging pretext. See Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 70, at 158–59 (citations omitted) (“While the majority never explicitly states that Texas enacted the admitting privileges and surgical center requirements with a purpose to obstruct women's access to abortion, the Court's deep skepticism of the state's actual motivation shines through the opinion. The Court repeatedly observes that the restrictions served little or no health benefit, and takes account of many ways the law adversely affected women's access. . . . The fact that, as Justice Breyer shows, Texas singled out abortion for onerous forms of health regulation that it did not apply to procedures of much greater risk only amplifies this suggestion. In her concurring opinion, Justice Ginsburg also emphasizes that the state had singled out abortion for onerous regulation that it did not direct at procedures of greater risk, and observes more bluntly: ‘Given those realities, it is beyond rational belief that H.B. 2 could genuinely protect the health of women, and certain that the law “would simply make it more difficult for them to obtain abortions.”’”).

87. See *supra* Part I.B.

the meaning and the effects of the state's new fetal remains regulation. They deserve consideration as judges weigh the benefit and burdens of the law.

B. Prochoicelife in Politics

Prochoicelife principles can guide decision making in law and in politics. Just as *Whole Woman's Health* scrutinized states that singled out abortion restrictions as a means of protecting women's health, courts can scrutinize states that single out abortion restrictions as a means of protecting potential life. But even if it takes years for judges to reason from prochoicelife principles in this way, advocates can appeal to prochoicelife principles in politics. Outside abortion law, they can ask, how do opponents of abortion protect new life?⁸⁸

88. It is not often that one hears prolife groups speaking about life saving outside the context of abortion, contraception, and perhaps euthanasia; but individuals raise questions about the implications of prolife commitments outside the abortion context with some frequency. For recent examples, see Scott Arbeiter, *I'm Pro-Life, and Pro-Refugee*, N.Y. TIMES (Feb. 7, 2017), <https://www.nytimes.com/2017/02/07/opinion/im-pro-life-and-pro-refugee.html> [<https://perma.cc/VA32-29BIH>] ("I now see that to be fully pro-life I must broaden my sense of morality and embrace a wider agenda."); Elizabeth Stoker Bruenig, *Pro-Life, Anti-Poverty*, AM. CONSERVATIVE (July 8, 2014), <http://www.theamericanconservative.com/articles/pro-life-anti-poverty> [<https://perma.cc/V4LE-VYDJ>] ("Fortunately, if the goal really is reducing abortion and supporting the ability of mothers to care for their infants, the data directs us to a very intuitive solution: give would-be moms, especially the poorest, the financial boost they need to give birth while maintaining financial security. A child allowance program fits the bill neatly."); Bryce Covert, *Why Abortion Is an Economic Issue*, N.Y. TIMES (Apr. 25, 2017), <https://www.nytimes.com/2017/04/25/opinion/why-abortion-is-an-progressive-economic-issue.html> [<https://perma.cc/AP33-BN2M>] ("[A]ny woman who has had to decide whether she could afford to keep a baby will most likely be able to tell you that economics is deeply embedded in her choice. To pretend that these issues are different and that one can be abandoned for the other is disproved in countless women's lives."); Heidi Schlumpf, *Breadth of Women's March Was Its Greatest Strength*, NAT'L CATH. REP. (Jan. 26, 2017), <https://www.ncronline.org/blogs/ncr-today/breadth-womens-march-was-its-greatest-strength> [<https://perma.cc/3X3P-S7DJ>] (featuring a photo of a placard at the 2017 Women's March on Washington saying that "Pro-life is Universal Health Care").

There is a little-known branch of the prolife movement that emphasizes that to truly support life, one must also oppose poverty, war, environmental degradation, and whatever else diminishes the dignity and potential of human life. Robert Christian, *What Is the Whole Life Movement?*, MILLENNIAL (Feb. 3, 2016), <https://millennialjournal.com/2016/02/03/what-is-the-whole-life-movement> [<https://perma.cc/F9TY-NFBE>]; CONSISTENT LIFE NETWORK, <http://www.consistentlifenetWORK.org> [<https://perma.cc/N9Y3-75H4>]. Though the sub-movement has existed since the 1980s, whole-lifers, or proponents of the "consistent life ethic," are generally dismissed by mainstream proliferators for "distracting" from their antiabortion goal. Joseph Cardinal Bernardin, Gannon Lecture at Fordham University: A Consistent Ethic of Life: An American-Catholic Dialogue (Dec. 6, 1983), <https://www.hnp.org/publications/hnpfocus/BConsistentEthic1983.pdf> [<https://perma.cc/QV5A-R52Z>]; Ramesh Ponnuru, *Pro-Life/Anti-Abortion*, NAT'L REV. (Aug. 28, 2017), <http://www.nationalreview.com/corner/450880/pro-lifeanti-abortion-which-term-use> [<https://perma.cc/JM9E-HSV6>] ("From first to last, we are anti-abortion. All else distracts."); see also *Symposium: Whole Life v. Pro-Life?*, HUM. LIFE REV. (Aug. 25, 2017), <http://www.humanlifereview.com/symposium-whole-life-v-pro-life> [<https://perma.cc/A2M3-WLPH>].

Advocates can appeal to prochoicelife principles in debating whether there is a role for opponents of abortion in progressive politics.⁸⁹ For some, support for abortion rights is a nonnegotiable element of progressive politics; but for others, the answer may depend on whether an opponent of abortion supports other choice-respecting means of protecting new life.

Prochoicelife arguments offer crucial resources in challenging abortion restrictions. Advocates can expand the frame and call upon government to protect life in ways that respect women's reproductive choices. They can mobilize these arguments in many settings: when advocates oppose restrictions on abortion in state legislatures and when they communicate with the public about the stakes of abortion rights litigation, as well as when they reason with judges about a legislature's justifications for restricting abortion.

Where expanding the frame fails to generate support for abortion rights, it may still generate support for other choice-respecting means of protecting life: providing comprehensive sex education, access to contraception, health care for pregnant women, and job protections for new mothers and mothers-to-be.

In this way, prochoicelife arguments have the potential to create bridges across polarized communities in red, blue, and purple states.

Consider the debates over health care that continue to consume the country. Because it is expensive for an individual to buy health insurance coverage for pregnancy and childbirth, the architects of the nation's health care law identified coverage for pregnancy, childbirth, and newborn care as an essential benefit that insurers must provide under the Affordable Care Act (ACA).⁹⁰ Yet in debating how

89. See Clare Foran, *Is There Any Room in the 'Big Tent' for Pro-Life Democrats?*, ATLANTIC (Apr. 27, 2017), <https://www.theatlantic.com/politics/archive/2017/04/pro-life-democrats-abortion-sanders-perez-party/524394> [https://perma.cc/6PUM-ESF3]; Perry Stein, *Is There a Place at the Women's March for Women Who Are Politically Opposed to Abortion?*, WASH. POST (Jan. 18, 2017), https://www.washingtonpost.com/local/social-issues/is-there-a-place-for-anti-abortion-women-at-the-womens-march-on-washington/2017/01/17/2e6a2da8-dcbd-11e6-acdf-14da832ae861_story.html [https://perma.cc/RTN9-RJ5M]. The manifesto of the Women's March reads in part: "We believe in Reproductive Freedom. We do not accept any federal, state or local rollbacks, cuts or restrictions on our ability to access quality reproductive healthcare services, birth control, HIV/AIDS care and prevention, or medically accurate sexuality education. This means open access to safe, legal, affordable abortion and birth control for all people, regardless of income, location or education. We understand that we can only have reproductive justice when reproductive health care is accessible to all people regardless of income, location or education." WOMEN'S MARCH ON WASH., GUIDING VISION & DEFINITION OF PRINCIPLES (2017), <https://static1.squarespace.com/static/584086c7be6594762f5ec56e/t/58796773414fb52b57e20794/1484351351914/WMW+Guiding+Vision+%26+Definition+of+Principles.pdf> [https://perma.cc/C9AS-WSWG].

90. Patient Protection & Affordable Care Act of 2010, Pub L. No. 111-148, 124 Stat. 119-1025. Prior to the ACA, insurance companies generally offered two plans—one with prenatal and maternity benefits, and one without. Requiring all plans to cover prenatal and maternity care spreads the risk. The same strategy of spreading risks leads men to purchase insurance that covers childbirth and women to purchase insurance that covers prostate cancer. Molly Redden, *GOP Hardliners Demand Maternity Benefits Be Nixed from Healthcare Bill*, GUARDIAN (Mar. 24, 2017) <https://www.theguardian.com/us-news/2017/mar/24/republican-healthcare-bill-maternity-benefits-affordable-care-act> [https://perma.cc/74KD-64PC]; see also Michael Hiltzik, *The*

to “repeal and replace Obamacare,” House Republicans would have changed the ACA to allow insurers to sell policies that do not cover these essential health benefits.⁹¹ Why?

The justification Illinois Representative John Shimkus offered for repealing the requirement that health insurance cover pregnancy commanded national attention. Shimkus objected to “men having to purchase prenatal care.”⁹² “People should not be forced to buy parts of a policy that they will never use,” said the congressman.⁹³ “Get rid of these crazy regulations that Obamacare puts in,” Iowa Representative Rod Blum urged, “such as a 62-year-old male having to have pregnancy insurance.”⁹⁴ The White House Press Secretary Sean Spicer defended excluding coverage from the Party’s health care bill: “Well, I think if you’re an older man you can generally say you’re not going to need maternity care.”⁹⁵ NARAL Pro-Choice America was quick to broadcast the objection on Twitter: “WOW. The #GOP’s reason to object to insurance covering prenatal care? ‘Why should men pay for it?’”⁹⁶

Representative John Shimkus believes government should not ask men to purchase insurance that covers the costs of prenatal care. At the same time, he opposes

Republican Plan To Gut Essential Health Benefits Is Truly Disastrous for All Americans, L.A. TIMES (Mar. 22, 2017, 12:45 PM), <http://www.latimes.com/business/hiltzik/la-fi-hiltzik-essential-health-benefits-20170322-story.html> [<https://perma.cc/4TZE-5H43>].

91. Susan Chira, *Yes, Senator, You Wouldn’t Want to Lose Your Mammograms—or Women Voters*, N.Y. TIMES (Mar. 23, 2017), <https://www.nytimes.com/2017/03/23/opinion/yes-senator-you-wouldnt-want-to-lose-your-mammograms-or-women-voters.html> [<https://perma.cc/85LG-7V8J>].

92. aaroncynic, *Rep. Shimkus Doubled Down on Prenatal Care Comments Last Weekend*, CHICAGOIST (Mar. 24, 2017, 1:58 PM), http://chicagoist.com/2017/03/14/rep_shimkus_doubles_down_on_prenata.php [<https://perma.cc/U7PG-BVD9>].

93. *Id.*

94. Avi Selk, *A Congressman Said Making a Man Get Maternity Insurance Was ‘Crazy.’ A Woman’s Reply Went Viral*, WASH. POST (May 15, 2017), <https://www.washingtonpost.com/news/the-fix/wp/2017/05/15/a-congressman-said-making-a-man-get-maternity-insurance-was-crazy-a-womans-reply-went-viral> [<https://perma.cc/638K-LCEL>].

95. Esme Cribb, *Spicer: Older Men ‘Can Generally Say’ They Don’t Need Maternity Care*, TALKING POINTS MEMO (Mar. 23, 2017, 2:49 PM) <http://talkingpointsmemo.com/livewire/sean-spicer-older-men-can-generally-say-they-dont-need-maternity-care> [<https://perma.cc/8MS6-DH5J>]. Republicans have raised this objection before. In 2013, then-Representative Renee L. Ellmers objected to being required to purchase coverage for unwanted care: “Do men not have to buy maternity coverage? . . . To the best of your knowledge, has a man ever delivered a baby?” Elise Viebeck, *‘Is that not correct?’: Male GOP Lawmaker Asks Why Men Should Pay for Prenatal Coverage*, WASH. POST: POWERPOST (Mar. 9, 2017), <https://www.washingtonpost.com/news/powerpost/wp/2017/03/09/is-that-not-correct-male-gop-lawmaker-asks-why-men-should-pay-for-prenatal-coverage> [<https://perma.cc/MA7M-AV4Z>]. Karl Rove argued in 2013 that the ACA mandates “expensive and often unnecessary provisions” such as “Essential Health Benefits” which “requires that every policy offer . . . maternity care (even for single men or women past childbearing age),” which he argued “drives up the cost of insurance.” Karl Rove, *Karl Rove: Voters May Cancel Democratic Coverage in 2014*, WALL ST. J. (Nov. 13, 2013, 7:31 PM), <https://www.wsj.com/articles/voters-may-cancel-democratic-coverage-in-2014> [<https://perma.cc/4GVG-FH3Y>].

96. Viebeck, *supra* note 95.

giving women the right to end a pregnancy: Shimkus has a zero percent rating by NARAL and a 100% rating by the National Right to Life Committee.⁹⁷ His profile resembles his party's. Since 1976, the Republican Party has called for amending the Constitution to ban abortion and force women to carry an unwanted pregnancy.⁹⁸ The party explains its positions as "Protecting Human Life" and demonstrating respect for "traditional family values and the sanctity of innocent human life."⁹⁹

What explains the views of John Shimkus and others in his party who believe law should force pregnant women to bear children, but should not require health insurance to cover contraception or prenatal, birth, and newborn care? Why disparage claims for freedom and impose obligations of care in one context, while simultaneously exalting claims for freedom and denying obligations of care in another? Why would those who oppose abortion to protect unborn life oppose health insurance coverage for contraception or prenatal care, delivery, and newborn care—when the government reports that newborns of mothers without prenatal care are five times more likely to die than children born to mothers who do receive prenatal care?¹⁰⁰

As we have seen, Shimkus' "prolife" views might reflect beliefs about women, sex, or property. He may disapprove of women who have sex but resist becoming mothers, and/or he may believe that protecting private property is more important than protecting pregnant women and newborns. Of course, not all who oppose abortion hold Shimkus's views. But debate over the House Republican Party's 2017 health care bill¹⁰¹ suggests that many do.¹⁰²

If legislators who oppose abortion could vote to repeal a requirement that health insurance cover contraception, prenatal care, delivery, and newborn care, then we do not in fact know what understandings animate legislators' opposition to abortion, *even when* legislators claim that they are acting out of respect for "traditional family values and the sanctity of innocent human life."¹⁰³

Pointing out that a prolife advocate is contradicting his apparent principles may create new sources of support for policies that help women avoid unwanted pregnancy and support women in carrying a wanted pregnancy to term.¹⁰⁴ If it does not,

97. *John Shimkus on Abortion*, ON THE ISSUES, http://www.ontheissues.org/IL/John_Shimkus_Abortion.htm [<https://perma.cc/3MJJ-PR5A>] (last updated July 5, 2016).

98. The 1976 Republican Party Platform stated, "The Republican Party favors a continuance of the public dialogue on abortion and supports the efforts of those who seek enactment of a constitutional amendment to restore protection of the right to life for unborn children." *Republican Party Platform of 1976*, AM. PRESIDENCY PROJECT (Aug. 18, 1976), <http://www.presidency.ucsb.edu/ws/?pid=25843> [<https://perma.cc/KG8R-YUFP>]. The 2016 Republican Party Platform mentions "abortion" thirty-five times. REPUBLICAN NAT'L CONVENTION, *supra* note 62.

99. REPUBLICAN NAT'L CONVENTION, *supra* note 62, at 13.

100. See *supra* note 5 and accompanying text.

101. American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017).

102. See *supra* notes 90–100 and accompanying text; see also American Health Care Act of 2017, H.R. 1628 (allowing states to apply to the Secretary of Health and Human Services for a waiver from the essential health benefits requirement and instead specify its own essential health benefits).

103. REPUBLICAN NAT'L CONVENTION, *supra* note 62, at 13.

104. Cf. Arbeiter, *supra* note 88 ("I now see that to be fully prolife I must broaden my sense of morality and embrace a wider agenda."). Some who oppose abortion may support

having the prochoice/life debate may teach Americans to understand the meaning of “prolife” commitments in new ways.

CONCLUSION

For too long, those who advocate restricting abortion have claimed the moral high ground by calling themselves prolife. For too long, courts have accepted at face value states’ claims that restrictions on abortion serve the state’s interest in protecting potential life. It is a question of fact whether claims of this kind are warranted. One needs to know how opponents of abortion protect life outside the abortion context to understand the values that likely drive their opposition to abortion.

This Essay invites states to demonstrate their prolife commitments by showing that the state protects life consistently rather than selectively: that the state leads in protecting life in ways that support women’s reproductive choices as well as in ways that restrict women’s choices.

Changing the conversation in this way has the potential to change the law and politics of abortion. But even if it cannot, it has the potential to bridge polarized communities and build support for protecting life in ways that promote reproductive freedom.¹⁰⁵

providing women effective contraception. Others who oppose contraception may support laws requiring employers to accommodate pregnant workers, or providing new parents paid leave.

105. See, e.g., Steven Findlay, *Paid Parental Leave May Be the Idea That Transcends Politics*, USA TODAY (July 23, 2017, 5:27 PM), <https://www.usatoday.com/story/news/nation/2017/07/22/paid-parental-leave-idea-could-transcend-politics/501967001> [<https://perma.cc/7PS9-8QCX>].